# AGENCY RESPONSE TO THE STATE QUALITY ASSURANCE (FS) FINDING

Complete, sign and return this form with documentation to:

Wisconsin Department of Health & Family Services
Division of Health Care Financing
Attn: Marcia Williamson
Bureau of Eligibility Management
P.O. Box 309
Madison, WI 53701-0309

(Place case information sticker here)

| **CARES Case Number** | **Case Name** |
|---|---|
| | |

☐ **We agree with the error finding.**
If necessary, correct the case and submit documentation of your corrective action within 30 days. If an overpayment occurred due to client error, establish a claim to initiate benefit recovery. To assist with error reduction initiatives, what information from the client, agency or state would have helped prevent this error? **Please respond within 30 days.**

☐ **We disagree with the error finding.**
Provide additional information and/or documentation to explain why you consider the eligibility determination to be correct. **You must respond within 10 days.**

☐ **We disagree with the QA determination of Agency Preventable Error.** Defend your agency position that the error could not be prevented by agency action. Attach all documentation that supports your position.

☐ **If client error, was this case referred for fraud?**

**Note:** Successful refutation of QA identified errors reduces Wisconsin's error rate and reduces potential agency liability for case specific disallowances and sharing of federally imposed sanctions.

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|---|---|
| **SIGNATURE** – Agency Representative | Date Signed |
| **SIGNATURE** – Agency Supervisor | Date Signed |

**AGENCY NAME**

Reset Form